STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF	Administrative Action
MILTON M. SMITH, M.D. License No. MA 39196	FINAL ORDER OF DISCIPLINE
TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY	

This matter was opened to the New Jersey State Board of Medical Examiners upon receipt of information which the Board has reviewed and on which the following findings of fact and conclusions of law are made.

FINDINGS OF FACT

1. Respondent, Milton M. Smith, M.D., License No. MA 39196, is a physician licensed in the State of New Jersey and has been a licensee at all times relevant hereto. He currently holds an active New Jersey medical license.

2. On or about January 14, 2003, the State of New York, Department of Health, State Board for Professional Medical Conduct ("New York Board") filed a Statement of Charges against Respondent charging him with twenty-four (24) specifications of professional misconduct. Specifically, it was alleged that Respondent committed professional misconduct by practicing the

profession fraudulently; by willfully, harassing, abusing or intimidating a patient either physically or verbally; by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice; by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department; and by engaging in negligence on more than one occasion in connection with the care and treatment of seven patients.

3. In a Hearing Committee Determination and Order ("Order"), entered October 28, 2003 by the New York Board, Respondent's license to practice medicine in New York State was revoked after the New York Board found Respondent to have engaged in professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of New York Education Law Section 6530(2) as charged in the First, Second, Third, Fourth, Sixth and Seventh Specifications of Charges, and as set forth in Findings of Fact 4 through 66 and 71 through 93; to have engaged in professional misconduct by reason of willfully harassing, abusing or intimidating a patient, either physically or verbally within the meaning of New York Education Law Section 6530(31) as charged in the Eighth, Ninth and Tenth Specification of Charges, and as set forth in Findings of Fact 4 through 13, 24 through 29, 31, 38, 81 through 87, 90 and 92; to have engaged in professional misconduct by reason of engaging in conduct in the

practice of medicine that evidences moral unfitness to practice within the meaning of New Ycrk Education Law Section 6530(20) as charged in the Eleventh, Twelfth, Thirteenth, Fourteenth and Seventeenth Specifications of Charges, and as set forth in Findings of Fact 4 through 66 and 71 through 93; to have engaged in professional misconduct by reason of willfully making or filing a false report within the meaning of New York Education Law Section 6530(21) as charged in the Eighteenth, Nineteenth, Twentieth, Twenty-First and Twenty-Third Specifications of Charges, and as set forth in Findings of Fact 16 through 19, 23, 33 through 39, 48 through 52, 61 through 66, 79 and 80; and to have engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of New York Education Law Section 6530(3) as charged in the Twenty-Fourth Specifications of Charges, and as set forth in Findings of Fact 4 through 14 and 71 through 93. (Copy of the Determination and Order and supporting materials are annexed hereto and made a part hereof.)

CONCLUSIONS OF LAW

1. The above disciplinary action taken by the sister state of New York provides grounds to take disciplinary action against Respondent's license to practice medicine and surgery in the State of New Jersey pursuant to N.J.S.A. 45:1-21(g) in that Respondent's license has been revoked in another state.

2. The above disciplinary action provides grounds to take disciplinary against Respondent's license *to* practice medicine and surgery in New Jersey pursuant to N.J.S.A. 45:1-21(b) in that it is based on findings that would give rise to discipline in this State for engaging in the use *of* dishonesty and fraud in practicing the profession of medicine.

3. The above disciplinary action provides grounds to take disciplinary action against Respondent's license to practice medicine in New Jersey in that it is based on findings that would give rise to discipline in this State for misconduct pursuant to N.J.S.A. 45:1-21(d) since Respondent has engaged in repeated acts of negligence and N.J.S.A. 45:1-21 (e) since Respondent has engaged in professional misconduct.

DISCUSSION ON FINALIZATION

Based on the foregoing findings and conclusions, a Provisional Order of Discipline, which provisionally suspended the respondent's license to practice medicine in this State until such time as his New York license is fully reinstated without restrictions, was filed on January 14, 2004, and a copy served on the respondent. The Provisional Order was subject to finalization by the Board at 5:00 p.m. on January 30, 2004, unless respondent requested a modification or dismissal of che stated Findings of Fact or Conclusions of Law by submitting a written request for modification or dismissal setting forth in writing any and all

reasons why said findings and conclusions should be modified or dismissed and submitting any and all documents or other written evidence supporting respondent's request for consideration and reasons therefor. *Any* submission was to be reviewed by the Board and the Board was to determine whether further proceedings were necessary.

In response to the Provisional Order, Zulima V. Farber, Esquire, counsel for the respondent, submitted a written correspondence, dated January 30, 2004, fer the Board's review on Dr. Smith's behalf, In this document, counsel for Dr. Smith, while acknowledging that the revocation of the respondent's license in New York could form the basis for suspension of his New Jersey medical license, requested that the Board dismiss or modify the findings of fact and conclusions of law detailed in the Provisional Order. In the alternative, Dr. Smith requested mitigation of the proposed suspension penalty.

Specifically, the respondent maintained that the Board should not discipline him based on the New York action because New York denied his due process rights in its conduct and management of the underlying administrative action and that it failed to afford him fundamental fairness. Hence, Dr. Smith argued that the New York proceedings were fatally tainted and that the Board should not utilize it as the basis to suspend his New Jersey license. In his response to the Provisional Order, the respondent asserted that he

was denied due process in the underlying action as a result of: false or materially inconsistent testimony from the witnesses; self-serving statements and alleged bias of the witnesses; and improper assessment of the weight of the evidence by the New York Board. He requested an opportunity to address the Board at a hearing *so* that he could ". . . clarify any issues that remain unclear, to emphasize important points and, in effect, to plead his case directly to the decision-makers."

Deputy Attorney General Michelle T. Weiner provided a written submission to the Board, dated February 5, 2004, on behalf of the Office *of* the Attorney General. In this submission, DAG Weiner detailed the procedural history of this matter and outlined the unanimous findings of fact of Dr. Smith's conduct made by the Hearing Committee of the New York Board subsequent to conducting an evidentiary hearing. She argued that the respondent was improperly attempting to challenge the New York Board's findings as to the credibility and alleged bias of various witnesses in this matter as well as the Mew York Board's assessment of the weight of the evidence presented.

DAG Weiner, while acknowledging Dr. Smith's request to present evidence OR mitigation evidence, maintained that the Board had ample grounds to suspend the respondent's New Jersey license based on the findings of the New York Board since Dr. Smith's infractions went directly to the practice of medicine and involved

professional misconduct and moral turpitude. The New York Board unanimously found that Dr. Smith, whose practice included a substantial amount of independent medical examinations, had: inappropriately touched the breasts and vaginal area of three female patients; repeatedly put his clothed penis into one patient's hand after asking her to open and close her hands; failed to perform an appropriate physical examination on seven patients; and, knowingly and intentionally preparing and submitting reports which he knew did not accurately report the actual nature and scope of his evaluations of six patients. DAG Weiner highlighted for the Board that the New York Board's determination was predicated on its finding that the six patients were credible witnesses and that its explicit determination that the respondent and his expert witness were not credible.

Via a letter to the Board, dated February 10, 2004, the respondent submitted further opposition to the Provisional Order and in reply to the February 5, 2004, submission by DAG Weiner. In this correspondence, Dr. Smith urged the Board to disregard DAG Weiner's submission since it "mischaracterized material facts" and disregarded crucial issues. He reiterated his position that the Board could not utilize the New York action as a basis to suspend his license in this State since he had been denied due process in the underlying action and again requested to address the Board so that all "legal issues and factual circumstances" could be properly

presented and considered.

On February 10, 2004, the Board considered whether to affirm or modify its Provisional Order, schedule an evidentiary and/or mitigation hearing. All materials submitted by both the respondent and the Deputy Attorney General were reviewed at this meeting, including, but not limited to: the transcripts of the nine (9) day administrative hearing before the New York Board; its twenty-two page Determination and Order; and Reports of Interview and complaint letters from the patients. The respondent had ample opportunity to present mitigation evidence and in fact did so in the form of a number of documents from character witnesses.[1] The Board determined however that further proceedings were not necessary and that no material discrepancies had been raised by Dr. Smith's response to the Provisional Order.

Following its review of the entire record, the Board determined that no information had been presented which altered its preliminary finding that the disciplinary action taken by the sister state of New York provided ample grounds to take disciplinary action against Dr. Smith's license to practice medicine and surgery in the State of New Jersey, pursuant to N.J.S.A. 45:1-21(g), since his license had been revoked in another state. The revocation of the respondent's New York license

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1 Respondent and counsel were present at the Board's February 10, 2004, meeting and requested an opportunity to be heard.

resulted from conduct which constitutes a long standing deviation from acceptable professional standards. Inappropriate sexual touching between a physician and patient is a violation of the basic and necessary trust patients place in their physicians. This trust *goes* to the heart of, and shapes, *a* doctor-patient relationship. The egregiousness of the respondent's misconduct is exacerbated by the fact that this conduct occurred under the guise of a legitimate medical examination.

Additionally, the Board found that action taken by New York provided grounds to take disciplinary action against the respondent's medical license, pursuant to N.J.S.A. 45:1-21(b) in that it is based on findings that would give rise to discipline in this State for engaging in the use of dishonesty and fraud in practicing the profession of medicine. Finally, the Board concluded that his conduct in New York would give rise to discipline in this State for misconduct since the respondent engaged in repeated acts of negligence and professional misconduct contrary to N.J.S.A. 45:1-21(d) and (e), respectively.

The Board finds that it is not its mandate or role to *go* behind the New York Board's determination and retry the underlying administrative action and make new credibility findings and assessments of the weight of the evidence as requested by the respondent in his written response to the Provisional Order. In New York, Dr. Smith was afforded a hearing, which lasted over nine

(9) days and in which he was represented by counsel, on the merits of misconduct allegations. He was able to confront witnesses and submit evidence to substantiate his position. Mitigation evidence was also considered by the New York Board. However, at the conclusion of the hearing and subsequent to its consideration of all relevant evidence, the New York Board revoked the respondent's license to practice medicine and surgery in New York based on its findings of his misconduct.

Following this determination, the respondent filed both an appeal of the New York Board's Revocation Order and an Order to Show Cause for a temporary stay of the New York Board's decision in a New York State Court. The stay application was denied by the New York Appellate Division on January 2, 2004. The Board finds that the pendency of an appeal of the underlying matter is irrelevant to its present determination. Presently, the ruling *of* the New York Board is controlling and the Board concludes that the nature of the respondent's misconduct is such that demands immediate action by the Board in order to protect the health and welfare of the citizens in New Jersey.

Contrary to the respondent's assertions, the Board finds that the proceedings in New Yerk demonstrated a careful and deliberate evidentiary process. In an effort to understand the basis for the New York Board's decision, the Board carefully reviewed the entire record; particularly the transcripts of the

administrative hearing, the Amended Statement of Charges and the Hearing Committee Determination and Order; in order to ascertain the core facts of Dr. Smith's alleged misconduct. The New York Board detailed its findings of facts relative to the respondent's offending conduct in its Determination and Order. The Board notes that the New York Board made specific and explicit credibility findings as to witnesses and weighed potential bias motivations of said witnesses. It also explicitly found that Dr. Smith and his expert witness were not credible. The New York Board considered the fact that the respondent had been acquitted in certain prior criminal actions which involved certain witnesses and properly concluded that the burden of proof standard in a criminal proceeding is more stringent than that required in the administrative process.

The respondent contends that the New York Board denied him due process and fundamental fairness in its consideration of the testimonies of Patients E and G in the underlying matter. He therefore asserts again that the Board cannot base its disciplinary action on the record established by the New York Board.[2] The Board finds that this argument is without merit. As to Patient E, the New York Board permitted one of its investigators to testify in lieu of the patient who was unavailable to testify after suffering

[2] The patients who testified before the New York Board were identified only as Patients A, B, C, D, E, F and G.

a stroke. In its Determination and Order, the New Yark Board explicitly disregarded the allegations of Patient E finding the investigator's testimony unconvincing "because of the number of information gaps in his investigation" of the patient complaint. Hence, the New York Board dismissed the allegations relating to Patient: E. Therefore, the Board concludes and is satisfied that the Patient E's allegations were *not* utilized in its disciplinary action against the respondent.

The respondent relies heavily upon the circumstances surrounding the inclusion of Patient G and her allegations, in the New York administrative proceedings, in support of his argument that the New York Board violated his due process rights. In addition to the administrative complaint, Patient G filed criminal charges against Dr. Smith relative to her allegations. The respondent apparently prevailed in the criminal matter. The respondent, among other contentions, argues that the New York Board by amending its Statement of Charges to include this patient's allegations from 1991 constituted a violation of due process and therefore cannot be used as a basis for the Board's disciplinary action in this State. Again, the Board finds that the respondent is again requesting this Board to *go* behind the New York Board's determination, retry the case and make credibility findings and assessments of the weight of the evidence afresh. This conduct is expressly rejected by the Board and proscribed by case law. *[See* In

re Coruzzi, 95 N.J. 557, 567-568 (1984); In re Cole, 194 N.J. Super. 237, 245 (1984)].

After its conscientious nine (9) day administrative proceeding, the New York Board revoked the respondent's license to practice medicine in that State. Additionally, his motion for a stay of the revocation was denied by the Appellate Division. The Board, following its consideration of the record in the underlying action, has concluded that it has a full understanding and interpretation of Dr. Smith's conduct and the evidence that was presented to the New York Board. It is convinced that the respondent was afforded the requisite due process in the underlying matter and specifically rejects Dr. Smith's arguments to the contrary. The Board concludes that it has ample grounds to suspend the respondent's license based on the findings of the New York Board. The respondent's conduct went directly to and is adverse to the practice of medicine and involved professional misconduct.

After nine days of hearings, the New York Board concluded that the testimony of the witnesses was credible that the respondent improperly touched the breasts and vaginal areas of three female and improperly rubbed his clothed penis against two of the patients. The testimony of Patient A describes in graphic detail the deplorable conduct of the respondent. She testified, through an interpreter, that

> And while he came to me, he stood behind me with his hands, he started to push me down

> **and** he **touched my breasts -- sorry.** And **he grabbed my breasts and he was squeezing them like** they **were** lemons. . . I've always **said that it felt** like **he was** milking **a cow.** And in **English, he asked me does** that hurt? **. . .** And I **told** him, ***yes*, because** you are **squeezing me.**
>
> And **then he grabbed** with his hand, he **lowered** them **- he** lowered **my pants and my panties and he touched my vagina. And with** part of **his hand, he was touching** the **bane that we have, but with his fingers, he** was **touching inside.**

In addition to the **inexcusable conduct detailed above,** the **New** York Board concluded **that** the **respondent had** failed **to** perform **appropriate physical examinations** on **seven patients** and **knowingly** and **intentionally prepared and submitted reports** that **did** not **accurately report the actual nature** and scope **of** the **independent evaluations** of **six patients.** The vile **nature** and **seriousness of** Dr. **Smith's conduct cannot be minimized** or **overlooked. The** Board **has ample precedent where suspension** and revocation were the **sanctions imposed** in cases **with similar reprehensible conduct;** for **example,** **In re Polk,** 90 N.J. 550, *578* (1982); **In re Schermer, 94 N.J.A.R. 2d 33 (BDS 1994), aff'd,** N.J.A.R. ***2d*** *33* (App. Div. 1996); In re Chunmuang, **93** N.J.A.R. *2d* (BDS) 27.

Further, the Board found nothing in Dr. **Smith's response tu** the **Provisional Order that demonstrated a need** for **a hearing** on **mitigation** of the Board's **decision.** The Board **found** that the **character witness documents submitted by** the respondent **adequately**

detailed Dr. Smith's position as to an appropriate sanction in this matter as well as the potential harm he may suffer if the Provisional Order *is* finalized. The Board found hence that a hearing to reiterate this mitigation evidence was unnecessary.

The Board thoroughly considered the record before it. Notwithstanding *his* challenges to New York Board's administrative procedures and the mitigation evidence presented by the respondent, the Board must take into consideration the public health, safety and welfare of the consumers in this State. The nature and the seriousness of the conduct engaged in by Dr. Smith cannot be minimized or overlooked and demand that the Board exercise *its* statutory mandate to protect the citizens of New Jersey, The Board concludes that the need to ensure a high level of public confidence in the character and integrity of those holding a license to practice medicine and surgery in the State warrant the imposition of the suspension of Dr. Smith's license until his New York License is reinstated. As stated earlier, sexual contact and improper sexual touching between a physician and patient are violative of professional standards and cannot be permitted. Hence, the suspension of the respondent's license sends a message that the Board will not tolerate such conduct; thus the penalty has both a punitive and deterrent effect. The Board's determination was announced on the record in public session at its February 10, 2004 meeting at which respondent was present. In order €or there to be

an orderly transition of patient care the suspension was made effective two weeks from the determination.

ACCORDINGLY, IT *IS* on this 26th day **of** February **2004;**

ORDERED THAT:

1. **Respondent's license** to **practice medicine and** surgery in the **State of** New Jersey shall **be and** hereby **is** suspended until such **time** as his **license to practice** medicine is **fully reinstated** in the State of **New** York without **restrictions** effective Thursday, **February *26*,** 2004.

2. **Prior to resuming active practice** in **New Jersey, Respondent** shall **be required to appear before the Board or a committee thereof *to* demonstrate fitness to** resume **practice.** *Any* **practice** in **this State** prior to **said appearance shall** constitute **grounds for** the charge **of** unlicenced **practice. In addition,** the **Board reserves** the right **to** place **restrictions** on **Respondent's practice** should his **license be reinstated.**

NEW JERSEY STATE BOARD OF
MEDICAL **EXAMINERS**

BY: David M. Wallace M.D

David M. Wallace, M.D
Board **President**

MILTON M. SMITH, M.D.
License #MA039196

ADDENDUM

Any licensee who is the subject of an order of the Board suspending, revoking or otherwise conditioning the license, shall provide the following information at the time that the order is signed, if it is entered by consent, or immediately after service of a fully executed order entered after a hearing. The information required here is necessary for the Board to fulfill its reporting obligations:

Social Security Number[1]:_____

List the Name and Address of any and all Health Care Facilities with which you are affiliated:

_____

_____

_____

_____

List the Names and Address of any and all Health Maintenance Organizations with which you are affiliated:

_____

_____

_____

_____

Provide the names and addresses of every person with whom you are associated in your professional practice: (You may attach a blank sheet of stationery bearing this information).

_____

[1] Pursuant to 45 CFR Subtitle A Section 61.7 and 45 CFR Subtitle A Section 60.8, the Board is required to obtain your Social Security Number and/or federal taxpayer identification number in order to discharge its responsibility to report adverse actions to the National Practitioner Data Bank and the HIP Data Bank.

DIRECTIVES APPLICABLE TO ANY MEDICAL BOARD LICENSEE WHO IS DISCIPLINED OR WHOSE SURRENDER OF LICENSURE HAS BEEN ACCEPTED

APPROVED BY THE BOARD ON MAY 10, 2000

All licensees who are the subject of a disciplinary order of the Board are required to provide the information required on the Addendum to these Directives. The information provided will be maintained separately and will not be part of the public document filed with the Board. Failure to provide the information required may result in further disciplinary action for failing to cooperate with *the* Board, as required by N.J.A.C. 13:45C-1 et seq. Paragraphs 1 through 4 below shall apply when a license is suspended or revoked or permanently surrendered, with or without prejudice. Paragraph 5 applies to licensees who are the subject of an order which, while permitting continued practice, contains a probation or monitoring requirement.

1. Document Return and Agency Notification

The licensee shall promptly forward to the Board office at Post Office Box 183, 140 East Front Street, 2nd floor, Trenton, New Jersey 08625-0183, the original license, current biennial registration and, if applicable, the original CDS registration. In addition, if the licensee holds a Drug Enforcement Agency (DEA) registration, he or she shall promptly advise the DEA of the licensure action. (With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board. In addition, at the conclusion of the term, the licensee should contact the DEA to advise of the resumption of practice and to ascertain the impact of that change upon his/her DEA registration.)

2. Practice Cessation

The licensee shall cease and desist from engaging in the practice of medicine in this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an opinion as to professional practice or its application, or representing him/herself as being eligible to practice. (Although the licensee need not affirmatively advise patients or others of the revocation, suspension or surrender, the licensee must truthfully disclose his/her licensure status in response to inquiry.) The disciplined licensee is also prohibited from occupying, sharing or using office space in which another licensee provides health care services. The disciplined licensee may contract for, accept payment from another licensee for or rent at fair market value office premises and/or equipment. In no case may the disciplined licensee authorize, allow or condone the use of his/her provider number by any health care practice or any other licensee or health care provider. (In situations where the licensee has been suspended for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is suspended, for the payment of salaries for office staff employed at the time of the Board action.)

A licensee whose license has been revoked, suspended for one (1) year or more or permanently surrendered must remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from professional listings, telephone directories, professional stationery, or billings. If the licensee's name is utilized in a group practice title, it shall be deleted. Prescription pads bearing the licensee's name shall be destroyed. A destruction report form obtained from the Office of Drug Control (973-504-6558) must be filed. If no other licensee is providing services at the location, all medications must be removed and returned to the manufacturer, if possible, destroyed or safeguarded. (In situations where a license has been suspended for less than one year, prescription pads and medications need not be destroyed but must be secured in a locked place for safekeeping.)

3. Practice Income Prohibitions/Divestiture of Equity interest in Professional Service Corporations and Limited Liability Companies

A licensee shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice. The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board action.

A licensee who is a shareholder in a professional service corporation organized to engage in the professional practice, whose license is revoked, surrendered or suspended for a term of one (1) year or more shall be deemed to be disqualified from the practice within the meaning of the Professional Service Corporation Act. (N.J.S.A. 14A:17-11). A disqualified licensee shall divest him/herself of all financial interest in the professional service corporation pursuant to N.J.S.A. 14A:17-13(c). A licensee who is a member of a limited liability company organized pursuant to N.J.S.A. 42:1-44, shall divest himlherself of all financial interest. Such divestiture shall occur within 90 days following the the entry of the Order rendering the licensee disqualified to participate in the applicable form of ownership. Upon divestiture, a licensee shaflforward to the Board a copy of documentation forwarded to the Secretary of State, Commercial Reporting Division, demonstrating that the interest has been terminated. If the licensee is the sole sharehotder in a professional service corporation, the corporation must be dissolved within 90 days of the licensee's disqualification.

4. Medical Records

If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shalt ensure that during the three (3) month period following the effective date of the disciplinary order, a message wilt be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month fur three (3) months in a newspaper of

general circulation in the geographic vicinity in which the practice was conducted. At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to medical records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her medical record or asks that record be forwarded to another health care provider, the licensee shall promptly provide the record without charge to ?he patient.

5. Probation/Monitoring Conditions

With respect to any licensee who is the subject of any Order imposing a probation or monitoring requirement or a stay of an active suspension, in whole or in part, which is conditioned upon compliance with a probation or monitoring requirement, the licensee shall fully cooperate with the Board and its designated representatives, including the Enforcement Bureau of the Division of Consumer Affairs, in ongoing monitoring of the licensee's status and practice. Such monitoring shall be at the expense of the disciplined practitioner.

{a) Monitoring of practice conditions may include, but is not limited to, inspection of the professional premises and equipment, and Inspection and copying of patient records (confidentiality of patient identity shall be protected by the Board) to verify compliance with the Board Order and accepted standards of practice.

(b) Monitoring of status conditions for an impaired practitioner may include, but is not limited to, practitioner cooperation in providing releases permitting unrestricted access to records and other information to the extent permitted by law from any treatment facility, other treating practitioner, support group or other individual/facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained by a rehabilitation program for impaired practitioners. If bodily substance monitoring has been ordered, the practitioner shall fully cooperate by responding to a demand for breath, blood, urine or other sample in a timely manner and providing the designated sample.

NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy wilt be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

(1) Which revokes or suspends (or otherwise restricts) a license,
(2) Which censures, reprimands or places on probation,
(3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obtigated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

October 30, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Milton M. Smith, M.D.
1000 Park Avenue
New York, New York 10028

Alexander G. Bateman, Esq.
Ruskin, Moscou, Faltischek, P.C.
East Tower, 15th Floor
190 EAB Plaza
Uniondale, New York 11556-0190

Leslie Eisenberg, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional
Medical Conduct
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Milton M. Smith, M.D.

Dear **Parties:**

Enclosed please find the Determination and Order **(No.** 03-286) of **the** Hearing Committee **in the above** referenced matter. This Determination **and** Order shall be **deemed** effective **upon the receipt or seven (7)** days after **mailing by certified mail as per** the **provisions** of §230, subdivision **10, paragraph** (h) of the **New York State Public Health Law.**

Five ***days*** after receipt of this **Order, you will** be required to deliver **to** the Board **of** Professional Medical Conduct your license to **practice** medicine together with the registration certificate. Delivery **shall be** by **either certified mail** or **in** person **to:**

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect If subsequently you locate *the* requested items, they must then be delivered *to the* Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct" Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by *the* Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. *Summary* orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt *of* the enclosed Determination and Order.

The notice of review served OR *the* Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau *of* Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
X

COPY

IN THE MATTER : HEARING COMMITTEE

OF :DETERMINATION

MILTON M. SMITH, M.D. :AND ORDER

X BPMC NO. 03-286

MICHAEL R. GOLDING, M.D., CHAIRPERSON, WOODSON MERRELL M.D. AND CONSTANCE DIAMOND, D.A., duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230 (10) (e) and 230 (12) of the Public Health Law. STEPHEN BERMAS, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

Dr. Golding was not present at a portion of the hearing Sessions conducted on March 13, 2003 and May 12,2003. Dr. Golding duly affirmed that he had read and considered the transcript of proceedings and the evidence received at such hearing Sessions prior to the deliberations in this matter on September 15, 2003. See Appendix A.

Dr. Merrell was not present at a portion of the hearing sessions conducted on April 28, 2003, May 5, 2003, May 12,2003, May 15, 2003 and May 29,2003. Dr. Merrell duly affirmed that he had read and considered the transcript of proceedings and the evidence received at such hearing sessions prior to the deliberations in this matter on September 15, 2003. See Appendix B.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	December 2, 2003
Amended Statement of Charges dated:	January 14,2003
Hearing Dates:	February 11,2003, March 13, 2003, April 28, 2003, April 29,2003, May 5,2003, May 12, 2003, May 15, 2003, May 29,2003 and July 21,2003
Deliberation Date:	September 15,2003
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York New York
Petitioner Appeared By:	Leslie Fisenberg, Esq. Associate Counsel Bureau of Professional Medical Conduct NYS Department of Health
Respondent Appeared By:	Ruskin Moscou Falteschek, P.C. by Alexander G. Batemen, Jr., Esq. and Nili S. Yolin, Esq.

STATEMENT OF CHARGES

The Amended Statement of Charges has been marked as Petitioner's Exhibit 1 and attached hereto as Appendix C.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of cited evidence. All findings are unanimous.

1. Milton M. Smith, Respondent, was authorized to practice medicine in New York State on or about July 1, 1972, by the issuance of license number 112612 by the New York State Education Department (Pet. Ex. 2).

2. Respondent is engaged in the private practice of orthopedic surgery, but he is not board certified in orthopedics or surgery (T. 982-3, 1048).

3. A substantial portion of Respondent's practice has been performing Independent Medical Examinations (IME's) (T. 863, 1070, 1072, 1390).

PATIENT A

4. On May 14, 2001, Patient A fell and broke her wrist and injured her right ankle and lower back. Patient A went by ambulance to Elmhurst Hospital where x-rays were taken of her wrist, ankle and back. (T26-28, 1491-1492).

5. Patient A underwent surgery for her left wrist at Elmhurst Hospital on June 5, 2003. (T28; Pet. Ex. 4)

6. Patient A sought medical treatment at QB Medical in Queens, New York, on June 12, 2003. On that date, Patient A met with an internist who took a history and examined her arm. Patient A was told that she would have to see an orthopedist for authorization to *receive* physical therapy. (T28-30, 51, 95; Pet. Ex. 3).

7, Patient A speaks Spanish; she does not *speak* my English. As a result, Patient A communicated with personnel at QB Medical through staff members who spoke Spanish. (T26, 29-30, 64).

8. On June 20, 2003, Patient A saw Respondent at QB Medical. Respondeat called Patient A into an examination room and the door was closed with nu one else in the room. Patient A informed Respondent that she did not *speak* any English. Respondent told her that he spoke a

little Spanish. Initially, Patient A sat in a chair near the desk and Respondent sat at the desk, asking Patient A, in Spanish, her name and where she was hurt. Patient A extended her left hand, which was swollen due to her recent surgery, and Patient A told Respondent that she felt pain in her lower back and ankle but that she came to him because of her hand. Respondent took some notes and then asked Patient A to stand in the middle of the office. (T30-31, 35, 69, 92-93).

9. Patient A stood in the middle of the examination room and Respondent stood behind her. Respondent squeezed Patient A's breasts first through Patient A's blouse and then underneath her shirt. (T31-32, 64).

10. Patient A previously had her breasts examined and testified that Respondent's touching was not a breast exam. (T36-37, 71).

11. While Patient A was standing in the middle of the examination room, Respondent placed his hands inside of Patient A's pants and panties and touched her vagina. Respondent had the palm of his hand on the pubic bone of Patient A's vagina and his fingers touched the inside of her vagina. Respondent was not performing a proper hip examination of Patient A, in that he improperly touched her vagina. (T32, 70-71).

12. Respondent moved Patient A's bra above her chest and he again grabbed her breasts. Respondeat leaned against Patient A's right side and *she* felt his erect penis against her body. (T32-33, 38, 71-72, 75, 79-80).

13. Patient A *went* home and immediately told her husband what happened. (T41).

14. Patient A had *not* provided Respondent with any medical records. If Respondent had medical records pertaining to Patient A, Respondent did not *ask* her any questions based on those records. (T39).

15. Respondent failed to perform an appropriate physical examination of Patient A as detailed by expert witness, Dr. Ramesh Gidumal. During the course of the encounter, Respondent never examined Patient A's back. Respondent did *not* touch or examine Patient A's rib cage. Respondent did not perform any range of motion tests on Patient A's neck, torso arms or legs. Respondent did not have Patient A walk on her heels and toes. Respondent did not check Patient A's reflexes in her arms or legs. Respondent did not examine the movements of Patient A's elbows, wrists, knees or ankles. Respondent did not have Patient A do leg raises or extensions. Patient A did not sit or lie down during the entire exam. Respondent did not use any tool or equipment during the course of the exam. (T39-41, 76, 81-82).

16. Respondent failed to perform and document an appropriate orthopedic examination of Patient A's wrist, which was one of her current complaints, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent failed to examine and document range-of-motion for all joints. Respondent failed to clearly document comparisons of the right and left wrist. Respondent failed to indicate which bone was injured and what type of injury occurred. Although Respondent indicated the presence of a scar, Respondent failed to specify where the scar is and failed to specify the type of scar. Similarly, Respondent noted tenderness and swelling without any specificity. In fact, Respondent failed to note any detail regarding the fact that Patient A had surgery on her wrist a few weeks prior to his examination. (T592-598, 626-628, 630-631, 636-637, 655, 1485-1486; Pet. Ex. 3).

17. Respondent could not have examined Patient A's wrists to determine that Tinel's sign was negative, as documented in his report, since Respondent did not touch Patient A's wrist with his fingers, a pin, pen or tool. (T598-600; Pet. Ex. 3).

18. Respondent did not perform an appropriate hip examination on Patient A as detailed by *expert* witness, Dr. Ramesh Gidumal. Although Patient A complained about back pain radiating *to* her left lower extremity at the time of her initial evaluation *at* QB Medical, Respondent failed to note whether this complaint continued or changed. Patient A did not lie down during the examination, which would have made a complete evaluation possible. Respondent failed to

document that he performed a hip examination as well as any pertinent findings of such an examination. (T624-625, 1492, 1620-1621; Pet. Ex. 3)

19. Respondent failed to perform and document an appropriate orthopedic examination of Patient A's right ankle, which was one of her current complaints, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent failed to examine and note range-of-motion, instability and strength. He did not indicate where the tenderness or swelling was, i.e. foot, ankle, top, side, middle, front or Achilles tendon. Respondent could not have examined Patient A's walk, as documented by Respondent, since Patient A did not walk on heels or toes. It is not possible for someone to walk well on heels and toes with the limitations in range-of-motion that Respondent documented. (T600-604, 630-631, 650-652; Pet. Ex. 3).

20. Patient A attempted to file a report with the police the day following the office visit, but when she went to the police precinct, she felt embarrassed and left because there were only men there. Patient A returned to the police precinct a few days later and reported Respondent's conduct. (T41, 78, 94-95).

21. Although Respondent admits that he performed an examination on Patient A on June 20, 2001, Respondent has no independent recall of this examination and testified based on his examination of report. (T1421, 1429, 1619).

22. Respondent submitted a bill for his examination of Patient A at the highest possible level although his records do not support that level of a comprehensive examination. (T622, 657; Pet. Ex. 3).

23. Respondent submitted a report of examination regarding Patient A to QB Medical that does not reflect the evaluation he performed on June 20,2001. (Pet. Ex. 33.

PATIENT B

24. On July 1, 2001, Patient B was a passenger in a car that was struck in the rear by another vehicle. Patient B injured her neck, back and shoulder and was taken by ambulance to a hospital in Marlboro County, South Carolina. Patient B was still in pain when she returned to New York about one week later, and went to Long Island College Hospital. Approximately one week later, Patient B was in a great deal of pain so she went to NYU Hospital. At each hospital, x-rays were taken and Patient B was given prescriptions for pain medication including Flexeril, Vicodin and Motrin. (T177, 211; Pet. Ex. 6a, 6b, 6c).

25. In the middle of July, 2001, Patient B sought medical treatment at QB Medical in Queens. At her initial visit, Patient B completed medical forms and was evaluated by a physician who recommended physical therapy. Patient B continued receiving physical therapy at QB Medical two or three times a week for several months. (T180-181, 216-617, 232; Pet. Ex. 5)

26. Patient B saw Respondent at QB Medical on September 24,2001. Patient B believed that Respondent was to determine if she needed surgery. Respondent called Patient B into the examination room, the door was closed and there was no one else in the room despite Respondent's testimony that there was always a chaperon present during that time period. Respondent sat at a desk and Patient B sat on the other side. Patient B was not asked to put on a gown Respondent then asked Patient B to stand and touch her toes. At this point, Respondent stood at Patient B's side and touched her back (T181-182, 184-185, 247-248).

27. Respondent asked Patient B to sit on the examination table and to open and close her hands. Respondent stood in front of Patient E. As Patient B opened and closed her hands, she felt Respondeat's clothed penis in her hand. Patient B initially thought that her hands were too close to the edge of the table so she moved her hands and continued to open and close her hands, as Respondent instructed. Respondent moved closer to Patient B and again Patient B felt Respondent's penis in her hand. Respondent asked Patient B to lie down on the table and to

continue opening and closing her hands. Patient B did so and again felt Respondent's penis in her hand. (T182-183, 186, 265, 268-269).

28. Respondent told Patient B that when you have neck pain, it can be accompanied by pain in the ribs. Respondent then touched Patient B's left breast through her shirt and then under her shirt, moving her bra. Respondent touched Patient B's nipple. Patient B described the touching as a caress; not like a breast exam where breasts are examined in a circular motion. Respondent did not examine Patient B's ribs. Respondent did not document a legitimate medical reason for his touching of Patient B's left breast. (T183, 186-187, 246, 273).

29. Respondent then told Patient B that when you have pain in *your* back, you have pain in your hips. However, Respondent did not perform an appropriate hip examination. He did not pulsate the hip areas. Respondent placed his hands through Patient B's *pants* on her pelvis, down the crease in her groin, touching her vagina. As Patient B was leaving she saw that Respondent's penis was erect. (T183-184, 187-188, 250, 270-272).

30. Respondent failed to perform an appropriate physical examination of Patient B as detailed by *expert* witness, Dr. Ramesh Gidumal. Respondent did not test Patient B's range-of-motion of her torso, arms or legs, or have her perform leg raises or extensions. Respondent did not have Patient B walk on heels and toes. Respondent did not touch Patient B's toes or have her move her toes. Respondent did not check Patient B's reflexes or pulses. Respondent did not utilize any tool or equipment such as a pin, feather or hammer. Respondent did not percuss Patient B's funny bone. (T188-190).

31. On the day following the incident, Patient B told her employer *about* Respondent's conduct and reported Respondent's *conduct* to the police. (T190-191).

32. Respondent has no independent recall of the examination of Patient B on September 24, 2001 and based his testimony on his records. (T1633-1634).

33. Respondent could not have examined Patient B's elbow and made a finding regarding the ulnar nerve and Tinel's sign as documented in his report, since Respondent did not press on Patient B's elbow or percuss Patient B's funny bone and ask if she had pain or tingling. (T188-189, 666-667; Pet. Ex 5).

34. Respondent failed to perform an appropriate examination of Patient B's shoulders, as detailed by expert witness, Dr. Ramesh Gidumal. Respondent's report does not indicate which of the three joints in the shoulder were examined nor does it reflect whether the findings are for one shoulder or both. (T188-189, 663-665; Pet. Ex.5)

35. Respondent could not have examined Patient B's knees and made findings that McMurray test is negative, as documented in his report, since Respondent did not have Patient B bend her knee so that her ankle touched her thigh and Respondent did not rotate her leg to determine if there was a torn meniscuses. Respondent could not have examined Patient B's knees and made findings regarding patella tracking since Patient B did not do leg raises. Respondent did not push Patient B's patella and Patient B had pants on during the examination so Respondent could not observe the patella. Moreover, since Patient B had her pants on and she did not lie on the examination table face down, Respondent could not have examined Patient B's knee and made findings regarding Baker's and popliteal cysts, as documented in his report. (T182-189, 669-671; Pet. Ex. 5)

36. Respondent could not have examined Patient B's lower extremities including reflexes, as documented in his report, since Respondent did not check any of Patient B's reflexes and Respondent did not use any tool or equipment during the examination. Respondent could not have made findings regarding Patient B's range-of-motion in her lower extremities since Respondent did not have Patient B do active or passive leg raises or any range-of-motion. (T188-189, 672-674; Pet. Ex. 5).

37. Respondeat could not have examined Patient B's extensor hallos longus as documented in his *report,* since Respondent did not have Patient B move her toes and Respondent did not touch her toes. (T184, 189, 673; Pet. Ex. 5).

38. Even though it would have been appropriate, based on Patient B's complaints, for Respondent to have Patient B open and close her hands, it was inappropriate for Respondent to position himself, on several occasions, such that his clothed penis rested in Patient B's hand while she opened and closed her hands. (T182-183, 186, 674-675, 681-682; Pet. Ex. 5).

39. Respondent submitted a report of examination regarding Patient B to QB Medical that does not reflect the evaluation he performed on September 24, 2001. (Pet. Ex. 5).

PATIENT C

40. On October 13, 2000, Patient C's automobile was struck in the rear while he was driving to work, and he injured his back, neck, left shoulder, groin and right wrist. Patient C was taken to NYU Downtown Hospital where he was evaluated and released. Patient C filed a worker's compensation claim. (T287-289).

41. Shortly after his accident, Patient C sought medical treatment at Queens Medical Rehabilitation, where he received physical therapy, two or three times a week, for almost a year. (T289; Pet. Ex.8).

42. On February 12,2001, Patient C saw Respondent in Respondent's office as directed by his insurance company. A woman dressed like a nurse *asked* Patient C questions about his medical background. Patient C was *called* into an examination room. Patient C, Respondent and a woman wearing white, were all in the room. *The* door remained open. Patient C remained clothed. Respondent had some medical records from Patient C's prior treatment. Respondent *asked* Patient C about his complaints but did not ask Patient C anything based on his medical records, (T290-296).

43. Respondent instructed Patient C to lift his head and raise his hands to the side. Patient C lifted his right hand but was moving his left hand slowly, due *to* pain in his shoulder. Respondent yanked Patient C's arm all the way up and Patient C told him to take it *easy*.

Respondent asked Patient C to walk on his toes and heels. Patient C told Respondent that he could not do so because he was weak on his left side, had painful sciatica and would lose his balance. Respondent asked Patient C to lift his shirt so Respondent could look at his back. Patient C pulled his shirt from inside his pants with his right hand. Respondent was facing Patient C and never looked at his back. (T292-293, 295, 354-355).

44. Respondent failed to perform an appropriate examination of Patient C as detailed by expert witness, Dr. Ramesh Gidumal. During the entire encounter, Respondent did not touch or palpate Patient C's neck or body. Respondent did not examine Patient C's back, chest, rib cage or wrists. Respondent did not check Patient C's range-of-motion of his torso, arms or legs. Respondent did not check Patient C's reflexes. Respondent did not touch Patient C's toes or have him move his toes. Patient C's shoes and socks were never removed. Respondent did not have Patient C perform leg raises or extensions. Patient C stood the entire time. Respondent did not utilize any tool or equipment such as a pen, feather or hammer. (T297-299, 349-350, 358).

45. In May 2001, Patient C was sent to another physician for another IME. Patient C testified that his examination was thorough and professional. Every part of his body was examined, touched and measured with special tools. Although that physician concluded that no additional therapy was required, Patient C did not complain about this physician because his exam was thorough and professional. (T300-302, 333).

46. A few weeks after seeing Respondent, Patient C was notified that his insurance would no *longer* cover his therapy, based on Respondent's report Patient C complained tu OPMC about Respondent's examination because he felt Respondent did not evaluate him independently for the insurance company and because Respondent wrote a report indicating he did tests that he never did. (T302-304).

47. Although Respondent admits that be performed *an* IME on Patient C on February 12, 2001, Respondent has no independent recall of this examination and testified based on his examination of report. (T1350-1351).

48. Respondent could not have examined Patient C's neck and made the findings documented in his report since Respondent did not touch or palpate Patient C's neck. (T292, 297, 718-719, 905-906, 921, 1362; Pet. Ex. 7).

49. Respondent could not have examined Patient C's upper extremities and made the findings documented in his report since Patient C did not do any range-of-motion testing and other than yanking his arm up, Respondent did not touch Patient C. (T292, 297, 719; Pet. Ex. 7).

50. Respondent could not have examined Patient C and made the findings regarding reflexes and knee/ankle jerks documented in his report since Respondent did not check Patient C's reflexes, Patient C did not sit or lie on the examination table and Respondent did not use any tools or equipment during the examination. (T297-299, 719; Pet. Ex. 7).

51. Respondent could not have examined Patient C's lower extremities including extensor hallos longus and made the findings documented in his report since Patient C did not do leg raises. Patient C stood the entire time and Patient C had his shirt, pants, shoes and socks on the entire time. (T297-299, 709-720; Pet. Ex. 7).

52. Respondent submitted a report of examination regarding Patient C to Med-Val, Inc. that does not reflect the evaluation he performed on February 12, 2001. (Pet. Ex. 7).

PATIENT D

53. On February 9,1997, Patient D, a licensed practical nurse, slipped on the ice as she was leaving her job at Nassau County Medial Center. As a result, Patient D injured her back, left shoulder and right wrist. Patient D filed a worker's compensation claim for her injuries. (T452-453).

54. Patient D sought medical treatment from Dr. Sunil Butani. Dr. Butani ordered x-rays, examined Patient D and, recommended physical therapy. Patient D received physical therapy

including ultrasound and massage, three times a week, then two, then one, until worker's compensation concluded her treatment in January 2001. (T455-456; Pet. Ex. 10).

55. On June 27, 1997, Patient D saw Respondent in his office as directed by the Worker's Compensation Board. A female staff employee named Ms. Smith took Patient D's history, brought Patient D into an examination room and closed the door. Ms. Smith stayed in the room with Respondent and Patient D. Respondent asked Patient D what part of her body she injured. Patient D told Respondent she injured her back, left shoulder and right wrist. (T459-461, 476).

56. Patient D sat on the examination table as instructed. Respondent yanked her left arm up; Patient D told Respondent he should not be so rough. Respondent told Patient D to get off the table and walk two steps forward and two steps back. Respondent asked Patient D to walk on her heels and toes. Patient D was not able to walk on her heels and toes. (T460-482).

57. Respondent failed to perform an appropriate examination of Patient C as detailed by expert witness, Dr. Ramesh Gidumal. During the encounter, other than yanking her arm, Respondent did not touch or palpate Patient D's neck, extremities or any other part of her body. Respondent did not examine or touch her rib cage or chest wall. Respondent did not have Patient D perform any range-of-motion exercises. Respondent did not check Patient D's reflexes and did not measure her extremities. Respondent did not use any tools or equipment during the exam. Respondent did not have Patient D do leg raises or extensions and Respondent did not check Patient D's toes or have her move her toes. Patient D did not lay down on the examination table and she did not take her shoes off. (T461-463)

58. Over the course of Patient D's medical treatment, Patient D had other IME's. Although the results of the other IMEs were similar to Respondents findings, Patient D has not complained about those physicians because their examinations were thorough and complete. (T464-470, 478, 491

59. In October 1997, Patient D complained to OPMC about Respondent's exam and the fact that he reported an exam that he didn't perform. (T464, 484, 486-487)

60. Although Respondent admits that he performed an IME on Patient D on June 27, 1997, Respondent has no independent recall of this examination and testified based on his examination of report. (T1118-1119, 1121, 1147-11478).

61. Respondent could not have examined Patient D's neck or upper extremities including shoulders and wrists, as documented in his report, since Respondent did not have Patient D do active or passive range-of-motion exercises. Respondent did not push on or pull Patient D's arm to see if there was instability in the shoulder joints and, other than yanking her arm up, Respondent did not touch or palpate Patient D. (T460-463, 731-734, 738, 932; Pet. Ex. 9).

62. Respondent could not have [redacted] Patient D's lower extremities including extensor hallos longus and reflexes and Respondent could not have made the findings documented in his report since Patient D did not do leg raises or extensions, patient D stood the entire time, Patient D's shoes were on the entire time and, Respondent did not use any tool or equipment during the examination. (T462-463, 738-740, 933-935, 942; Pet Ex. 9).

63. Respondent failed to perform and note appropriate measurements of arm and leg circumference. Patient D testified that Respondent did not measure her arms and legs. Even if Patient D is incorrect and Respondent did take these measurements, Respondent failed to indicate a reference point to indicate where the measurements were taken. (T746-747, 939; Pet. Ex. 9).

64. Although it would have been appropriate for Respondent to perform a hip examination on Patient D, based on her complaint of back pain, Respondent did not perform a hip exam on Patient D. There is no notation in his worksheet or report indicating that he did a hip exam. In addition, in order for Respondent to perform an appropriate hip exam, Respondent would have had to palpate Patient D's hip area while she was lying face-up on the exam table, or Respondent would have had to examine Patient D's hips while she sat on the table and did leg raises. However, Patient D did not lie or sit on the exam table nor did she do leg raises and Respondent did not palpate Patient D. (T459-460, 463, 1146-1147; Pet. Ex. 9).

65. Respondent failed to perform and note an appropriate orthopedic examination in that he failed to document any specifics regarding his findings. For instance, Respondent's report indicates that Patient D has no instability in the wrist. Even though one of Patient D's current complaints was right wrist, Respondent failed to note where the instability is or whether he is talking about the ulnar collateral ligaments on the thumb or the scaphold lunate area. (T733-734; Pet. Ex. 9)

66. Respondent submitted a report of examination regarding Patient D to Crossland Medical Services that does not reflect the evaluation he performed on June 27, 1997. (Pet. Ex. 9)

PATIENT E

67. Patient E had a stroke earlier this year. As a result, he was unavailable to testify. However, Senior Medical Conduct Investigator John Flynn, the investigator responsible for investigating complaints regarding Respondent, testified regarding Patient E. John Flynn conducted a telephone interview with Patient E on or about November 30, 2001. (T498-500)

68. Patient E was in a car accident on June 4, 1999 and suffered injuries to his neck and lower back. He sought medical treatment from Dr. Ku, Dr. Broadbeck and Dr. Hammershlag. Patient E filed a Worker's Compensation claim for his injuries. (T500-501; Pet., Ex. 12, 13.

69. Although Respondent admitted he performed *an* IME for Patient E on September 30, 1999, he has no independent recall of the examination and testified based on his report of examination. (T1296-1298).

70. Respondent submitted a report of examination regarding Patient E to First Rehabilitation Insurance Company of America. (Pet. Ex. 11)

PATIENT F

71. On October 2, 1997, Patient F's automobile was struck in the rear while she was driving to work. She developed stiffness and pain in her neck and lower back and went to North Shore University in Plainvew, New York. X-rays were taken and Patient F was given prescriptions for medication and a cervical collar. (T107-109, 119; Pet. Ex. 15).

72. On October 7, 1997, Patient F sought medical treatment with Barry Fisher, M.D. Dr. Fisher diagnosed Patient F with cervical radiculitis, low back derangement and bulging discs and recommended physical therapy treatment. Patient F received physical therapy at North Shore Sports Institute from October 8, 1997 thorough February 11, 1998. (T109, 119, 130; Pet. Ex. 17).

73. *On* January 22,1998, Patient F saw Respondent in his office as directed by her insurance company. Patient F entered an examination room and put on a gown. Respondent entered the room accompanied by a woman who stood in the doorway throughout the course of the examination Although Patient F does not recall much detail of the examination, she does recall that it was a short exercise that included standing, walking on her heels and toes and flexing at the waist. (T110-114, 133-138).

74. Respondent failed to perform an appropriate physical examination of Patient F as detailed by expert witness, Dr. Ramesh Gidumal. Patient F testified that the entire examination lasted less than five minutes, that Respondent *never* touched her during the examination, that. Respondent did not tell her what he was doing as he was doing it and did not inquire about how she felt when doing *the* things he instructed her to do. (T110-114, 133-138).

75. Patient F did not provide Respondent with any medical records and did not ask her any questions regarding my medical records he may have had. (T154, 158, 165).

76. On February 13, 1998, Patient F had another IME performed by Alan Wolf, M.D. The results of Dr. Wolf's examination were similar to Respondent's in that they both concluded that Patient F was capable of returning to work. However, Patient F testified that Dr. Wolf's examination was much more thorough than Respondent's. (T115-117, 152-153).

77. Some time after Respondent's examination, Patient F was notified that her insurance company denied any further treatment based on Respondent's report of examination. On April 1, 1998, Patient F complained to the New York State Insurance Department about Respondent's conduct. Patient F complained because she believed Respondent's examination was inadequate and that he could not have prepared an apparently complete report based on the limited examination he conducted. (T115, 117, 141, 144-145, 149).

78. Respondent admits that he performed an IME on Patient F on January 22, 1998, but Respondent has no independent recollection of this exam and testified based on his report of examination. (T1168).

79. Respondent could not have examined Patient F's neck, measured her arms and legs and made findings regarding reflexes or warmth, tenderness and strength, all as documented in his report, since Respondent did not 'touch Patient F. (T135, 1174; Pet. Ex. 14).

80. Respondent submitted a report of examination regarding Patient F to Allstate that does not reflect the evaluation he performed on January 22, 1998. (Pet. Ex. 14).

PATIENT G

81. On December 13,1989, Patient G was injured. Patient G experienced pain in her neck and left shoulder, shooting pain down her left arm and a creak in her hip. Patient G filed a worker's compensation claim for her injuries. Patient G received medical treatment for several months. (T362-364).

82. In May 1991, Patient G sought additional medical treatment for her injuries since she was experiencing recurrent symptoms. Patient G needed authorization from a physician before she could receive physical therapy. (T364-366, 415-416).

83. On Tuesday, May 21, 1991, Patient G went to see Respondent at his office. Patient G complained of pain down her left arm, soreness in her left shoulder and lower back and creaky hips. Patient G was called into an examination room and a medical history was taken. Respondent instructed Patient G to take off her clothing and put on a gown. Patient G removed her bra and clothing and put the gown on. Patient G sat on the examination table. Respondent re-entered the room. The door was closed and there was no one else present in the room. (T366-368, 372-373).

84. Respondent had Patient G move her head in different directions and he asked her if it hurt. Respondent continued examining Patient G's range-of-motion of her shoulders, head and arm. Respondent had Patient G stand and Respondent stood behind her. Respondent held Patient G's left hip with his left hand, and with his right hand Respondent went down from the top of her back to her lower back, including the buttocks, spending a lot of time at the crease between her buttocks and thigh, continually asking if it hurt. Respondent touched Patient G on the right side, between the buttocks and thigh and on the left side as well. Respondent touched the lips of Patient G's vagina, several times. Respondent touched Patient G's labia major and labia minor. Respondent did not put his hand in Patient G's vaginal canal. Patient G tried to move away but Respondent followed her as she moved. (T368-369, 395-397, 420, 426, 439-440).

85. Respondent felt Patient G's rib cage and sternum and cupped her left breast. Respondent did not perform a breast examination. When Respondent *cupped* her breast, Patient G snapped and asked Respondent if he was done. Respondent said yes and told Patient G to get dressed and go for x-rays. (T369-370, 374-375, 403-404).

86. During *the* course of *this* encounter, Patient G was unsure about the legitimacy of the examination. (T369-370, 389, 397, 400-401).

87. When Patient G left the room she warned women in the waiting room that something weird just happened. Patient G went for x-rays. Patient G started to cry and told the x-ray technician, Delores Taylor, what Respondent had done. Although Patient G wanted to leave, she returned to Respondent's office because she needed a referral for physical therapy. Respondent gave Patient G a referral and she left. (T370-371, 399-400).

88. Respondent failed to perform an appropriate physical examination of Patient G as detailed by expert witness, Dr. Ramesh Gidumal. During this encounter, Respondent did not touch Patient G's feet and ankles. Respondent did not have Patient G move her toes. Respondent did not use tools or equipment such as a pin. Respondent did not have Patient G perform leg raises or extensions. Other than when Respondent initially entered the room and examined Patient G's range-of-motion in her neck, Patient G did not sit or lie down on the exam table. (T372-373, 376-377, 427).

89. After leaving Respondent's office, Patient G went back to work and told a co-worker and several friends what Respondent had done. Patient G called a rape crisis hotline and filed a complaint with the police. Respondent was arrested within three days of the examination. (T378-381, 1116).

90. Approximately one week later, Patient G complained about Respondent's conduct to the Office of Professional Medical Conduct. Patient G was interviewed and then notified that the case would be closed. In 2001, Patient G was re-contacted and notified that the case had been re-opened. (T383-384, 422-424).

91. Respondent admits to performing an examination on Patient G on May 21,1991, but Respondent has no independent recall of this examination and testified based on his medical records. (T1018).

92. There is no evidence that Respondent performed a hip *exam.* Patient G would have had to lie on the *exam* table, face-up, which she did nut do. By touching Patient G's vaginal lips and

crease between her thigh and buttocks, Respondent inappropriately touched Patient G's vaginal area and buttocks. (T367-370, 1026-1027, 1043, 1091).

93. Although it would have been appropriate for Respondent to examine Patient G's chest wall based on complaints of shoulder pain radiating down her arm, there is no evidence that Respondent performed such an examination. Respondent simply cupped Patient G's left breast, which was inappropriate. (T367-370, 1026-1027, 1043, 1091).

DISCUSSION

The Hearing Committee found Patients A, B, C, D, F and G to be credible witnesses. The fact that some of them had instituted civil actions against Respondent was considered, but did not in the Committee's opinion lessen their credibility. Furthermore, the institution of a civil action does not in any way have any probative value as to the adequacy of the physical examinations or the appropriateness of the physical touchings. Similarly, the fact of Respondent's acquittal in certain prior criminal proceedings in which some of these patients testified did not lessen their credibility. The Committee is aware of the different standards of proof in criminal proceedings and in this pending proceeding.

The Committee did not find Respondent to be a credible witness. By his own admission he had no present recollection of any of these patients. His responses to his own counsel (T. 1397-1400) as well as to opposing counsel (T. 1058-1059, 1069, 1078-1080) and Committee members, (T. 1158-1164, 1336-1343) were evasive and unresponsive to the questions asked. The answers were directed at establishing Respondent's general medical competence rather than at providing the information sought.

The Committee did not find John Flynn's testimony convincing because of the number of information gaps in his investigation of Patient E's complaint. (T. 503, l. 16-18, T. 506, l. 17-19, T. 518, l. 16, T. 519, l. 2).

The Committee found Dr. Ramesh Gibumal a credible expert witness who addressed the issues directly and informatively. By contrast, Dr. Joel Teicher appeared to be unduly based in Respondent's behalf and trying too hard to defend the Respondent against any claim of wrong doing. See pages 1538-1539 of the transcript. In several instances he testified that although good medical practice required a particular examination procedure, he could imagine a situation where the procedure followed by Respondent was adequate. See pages 1267-1271 of the transcript. Dr. Michael Pierre Rafiy appeared confused by many of the questions and his answers were too vague to be informative. For example, on pages 909-910 of the transcript, he first said something was consistent and then said it was inconsistent. At pages 918-919 he first testified that he had previously testified in his own defense and then said he had not.

CONCLUSIONS OF LAW

FIRST: Respondent is found to have *engaged* in professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of N.Y. Education Law Section 6530 (2) as charged in the FIRST, SECOND, THIRD, FOURTH, SIXTH and SEVENTH Specifications of Charges, and as *set* forth in Findings of Fact 4 through *66* and 71 through 93, supra.

SECOND: Respondent is found to have engaged in professional misconduct by reason of willfully harassing, abusing or intimidating a patient, either physically or verbally within the meaning of N.Y. Education Law Section 6530 (31) as charged in the EIGHTH, NINTH and TENTH Specifications of Charges, and as set forth in Findings of Fact 4 through 13, 24 through 29, 31, 38, 81 through 87, 90 and 92, supra.

THIRD: Respondent is found to have engaged in professional misconduct by reason of engaging in conduct in the practice of medicine that evidences moral unfitness to practice within the meaning of N.Y. Education Law Section 6530 (20) as charged in the ELEVENTH, TWELFTH, THIRTEENTH, FOURTEENTH, SIXTHEENTH and SEVENTEENTH Specifications of Charges, and as set forth in Findings of Fact 4 through 66 and 71 through 93, supra.

FOURTH: Respondent is found to have engaged in professional misconduct by reason of willfully making or filing a false report within the meaning of N.Y. Education Law Section 6530 (21) as charged in the EIGHTEENTH, NINETEENTH, TWENTH, TWENTY-FIRST and TWENTY-THIRD Specifications of Charges, and as set forth in Findings of Fact 16 through 19, 23, 33 through 39, 48 through 52, 61 through 66, 79 and 80, supra.

FIFTH: Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Education Law Section 6530 (3) as charged in the TWENTY-FOURTH Specification of Charges, and as set forth in Findings of Fact 4 through 14 and 71 through 93, supra.

SIXTH: Respondent is not found to have engaged in professional misconduct as charged in the FIFTH, FIFTEENTH and TWENTY-SECOND Specifications of Charges, relating to Patient E because of the lack of sufficient evidence presented to support said charges.

ORDER

The Hearing Committee determines and orders that Respondent's license to practice medicine in New York State be revoked.

Michael R. Golding, M.D.
Chairperson

Woodson Merrell, M.D.

Constance Diamond, D.A.

Dated: New York, NY
October 28, 2003

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	AFFIRMATION
OF	:	OF MEMBER OF THE
MILTON M. SMITH, M.D.	:	HEARING COMMITTEE

MICHAEL R GOLDING, M.D., a *duly* designated member *of* the State Board for Professional Medical Conduct and of the Hearing Committee thereof designated to hear the MATTER OF MILTON M. SMITH, M.D., hereby affirms that he was not present at *a* portion of the hearing sessions conducted on March 13,2003 and May 12, 2003. He further affirms that he has read and considered the transcript of proceedings and *the* evidence received at such hearing sessions prior *to* deliberations of the Hearing Committee on the 15th day *of* September, 2003.

DATED: October 6, 2003

Michael R. Golding, M.D.

APPENDIX A

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER		AFFIRMATION
OF	:	OF MEMBER OF THE
MILTON M. SMITH, M.D.	:	HEARING COMMITTEE

WOODSON MERRELL, M.D., a duly designated member of the State Board for Professional Medical Conduct and of the Hearing Committee thereof designated to hear the MATTER OF MILTON M. SMITH, M.D., hereby affirms that he was not present at a portion of the hearing sessions conducted on April 28,2003 and May 5, 12, 15 and 29,2003. He further affirms that he has read and considered the transcript of *proceedings* and the evidence received *at* such hearing sessions prior to deliberations of the Hearing Committee on the 15th day of September, *2003.*

DATED: October 6,2003

Woodson Merrell, M.D.

APPENDIX B

2-6-03

NEW YORK STATE DEPARTMENT Of HEALTH
STATE BOARD FUR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

MILTON M. SMITH, M.D.

AMENDED STATEMENT

OF

CHARGES

Milton M. Smith, M.D., the Respondent, was authorized to practice medicine in Jew York State on or about July 1, 1972, by the issuance of license number 112612 by the New York State Education Department,

FACTUAL ALLEGATIONS

4. Patient A was seen by Respondent at 34-09 Queens Boulevard, Queens, New York, for evaluation, on June 20,2001, in connection with injuries to her left wrist, sustained in a fall, on May 14, 2001. Respondent thereafter wrote a report of examination for QB Medical. (The names of patients are contained in the attached Appendix.)

1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient A as follows:

   a. Respondent inappropriately touched Patient A's breasts;

   b. Respondent inappropriately touched Patient A's vaginal area, and;

   c. Respondent inappropriately rubbed his clothed penis against Patient A's body.

2. Respondent failed to perform an appropriate physical examination.

3. Respondent knowingly and intentionally prepared and submitted to QB

APPENDIX C

A

Medical a report of his examination of Patient A, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient A.

a. Respondent intended to mislead the recipient@)of the report.

B. Patient B was seen by Respondent at 34-09 Queens Boulevard, Queens, New York, for evaluation, on September 24,2001, in connection with neck and back injuries sustained in a car accident, on July 1 , 2001. Respondent thereafter wrote a report of examination for QB Medical.

1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient B as follows:

   a. Respondent inappropriately rubbed his clothed penis against Patient B's hand;

   b. Respondent inappropriately touched Patient B's breasts, and;

   c. Respondent inappropriately touched Patient B's vaginal area.

2. Respondent failed to perform an appropriate physical examination.

3. Respondent knowingly and intentionally prepared and submitted to QB Medical a report of his examination of Patient B, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient B.

   a. Respondent intended to mislead the recipient(s) of the report.

C. Patient C was seen by Respondent at 112-47 Queens Boulevard, Forest Hills, New York, for evaluation, on February 12, 2001, in connection with neck, back and shoulder injuries sustained in a work-related car accident, on October 13, 2000. Respondent thereafter wrote a report of examination for MED-VAL Inc..

1. Respondent failed to perform an appropriate physical examination.

2. Respondent knowingly and intentionally prepared and submitted to MED-Val Inc. a report of his examination of Patient C, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient C.

   a. Respondent intended *to* mislead the recipient(s) of the report.

D. Patient D was seen by Respondent at 1670 Old Country Road, Plainview, New York, for evaluation, on June 27, 1997, in connection with back, shoulder and wrist injuries sustained in a work-related fall, on February 9, 1997. Respondent thereafter wrote *a* report of examination for Crossland Medical Services, P.C..

1. Respondent failed *to* perform an appropriate physical examination.

2. Respondent knowingly and intentionally prepared and submitted to Crossland Medical Services, P.C., a report of his examination of Patient D, which he knew to be false in that it did not accurately report the actual nature and scope of his evaluation of Patient D.

   a. Respondent intended to mislead the recipient(s) of the report.

E. Patient E was seen by Respondent at 1719 North Ocean Avenue, Medford, New York, for evaluation, on September 30, 1999, in connection with neck and back injuries sustained in a motor vehicle accident, on June 4, 1999. Respondent thereafter wrote a report of examination for the First Rehabilitation Insurance Company of America.

1. Respondent failed to perform an appropriate physical examination.

2. Respondent knowingly and intentionally prepared and submitted to the First Rehabilitation Insurance Company of America a report of his examination of Patient E, which he knew to be false in that it did not accurately report the nature and scope of his evaluation of Patient E.

   a. Respondent intended to mislead the recipient(s) of the report.

F. Patient F was seen by Respondent at 3670 Old Country Road, Plainview, New York, for evaluation, on January 22, 1998, in connection with back injuries sustained in a motor vehicle accident, on October 2, 1997. Respondent thereafter wrote a report of examination for Allstate.

1. Respondent failed to perform an appropriate physical examination.

2. Respondent knowingly and intentionally prepared and submitted to Allstate a report of his examination of Patient F, which he knew to be false in that it did not accurately report the nature and scope of his evaluation of Patient F.

   a. Respondent intended to mislead the recipient(s) of the report.

G. Patient G was seen by Respondent at 749 Union Street, Brooklyn, New York, for evaluation, on May 21, 1991, in connection with injuries to her back, sustained in a work-related accident, on December 13, 1989.

1. In the course of a purported physical examination but not for a legitimate medical purpose, Respondent inappropriately touched Patient G as follows:

   a. Respondent inappropriately touched Patient G's vaginal area and buttock, and;

   b. Respondent inappropriately touched Patient G's

breast;

2. Respondent failed to perform an appropriate physical examination.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraph A and its respective subparagraphs.
2. Paragraph B and its respective subparagraphs.
3. Paragraph C and its respective subparagraphs.
4. Paragraph D and its respective sub-paragraphs.
5. Paragraph E and its respective subparagraphs.
6. Paragraph F and its respective sub-paragraphs.
7. Paragraph G and its respective subparagraphs,

EIGHTH THROUGH TENTH SPECIFICATIONS

WILLFULLY HARASSING. ABUSING OR INTIMIDATING A PATIENT

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(31) by willfully harassing, abusing or intimidating a patient either physically or verbally, as alleged in the facts of the following:

8. Paragraph A and A I and its respective subparagraphs.
9. Paragraph B and B1 and its respective sub-paragraphs,
10. Paragraph G and G I and its respective subparagraphs.

ELEVENTH THROUGH SEVENTEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

11. Paragraph A and its *respective* subparagraphs
12. Paragraph B and its respective sub-paragraphs.
13. Paragraph C and its respective subparagraphs.
14. Paragraph D and *its* respective sub-paragraphs.
15. Paragraph E and its respective subparagraphs.
16. Paragraph F and its respective sub-paragraphs.
17. Paragraph G and its respective subparagraphs.

EIGHTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

WILLFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

18. Paragraph A and A3.
19. Paragraph B and B3.
20. Paragraph C and C2.
21. Paragraph D and D2.
22. Paragraph E and E2.

23. Paragraph F and F2.

TWENTY-FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

24. Paragraph A and A2 and/or, Paragraph B and B2 and/or, Paragraph C and C1 and/or, Paragraph D and D1 and/or, Paragraph E and E1 and/or, Paragraph F and F1 andlor, Paragraph G and G2.

DATED: January 14, 2003
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
Milton Smith, M.D.

NOTICE
OF
HEARING

TO: Milton Smith, M.D.
c/o Jankoff & Gabe, P.C.
575 Lexington Avenue
New York, NY 10022

PLEASE TAKE NOTICE:

A hearing will be hetd pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-*307* and 401. The hearing will be conducted before a committee on professionalconduct of the State Board *for* Professional Medical Conduct on January 16, 2003, at 10:00 a.m., at the Offices of *the* New York State Department of Health, *5* Penn Plaza, 6th Floor, NYC 10001, and *at* such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement *of* Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules *is* enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division *of* Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth Bureau of Adjudication"), (Telephone: (518-402-0748)? upon *notice* to *the* attorney for

the Department of Health whose name appears below, and at least five days prior *to* the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

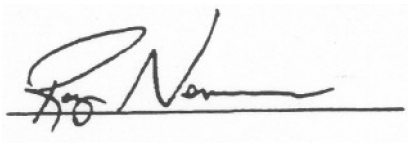
Pursuant to the Provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department *of* Health whose name appears below. Pursuant to §301*(5)* of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings *to,* and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, *the* committee shall make findings of fact, conclusions concerning the charges sustained or *dismissed,* and in the event any of the charges are sustained, *a* determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET

OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATER.

DATED: New York, New York
December 2,2002



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Leslie Eisenberg
Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
NYC 10001
212-268-6806

NYS DEPT. HEALTH
COUNTY OF

291 BROADWAY, SUITE 1324
NEW YORK, NY 10007
LIC. # 887-054

Index No.

IN THE MATTER OF MTLTON SMITH M.D.,

Plaintiff(s)

DATE 01/16/03

AFFIDAVIT OF SERVICE

- against -

Defendant(s)

NOTICEOF HEARING, STATEMEN
OF CHARGES, REGULATIONS

STATE OF NEW YORK: COUNTY OF NEW YORK ss:

ANDRE ADAMSON BEING DULY SWORN DEPOSES AND SAYS DEPONENT IS NOT A PARTY TO THIS ACTION AND IS OVER THE AGE OF EIGHTEEN YEARS AND RESIDES IN THE STATE OF NEW YORK

That on 12/17/02 at 1053AM Hours at 189 MONTAGUE STREET # 801 A BROOKLYN, NEW YORK 11201
deponent served the within NOTICEOF HEARING, STATEMENT OF CHARGES, REGULATIONS
MILTON SMITH M.D. therein named,

INDIVIDUAL A [X] by delivering a true copy of each to said personally; deponent knew the person so served to be the person described as said perso therein. [X] (S) He identified (her) himself as such.

CORPORATION B [ ] a (domestic) (foreign) corporation by delivering thereat a true copy of each to personally, deponent knew said corporation so served to be the corporation described in legal papers and knew sai individual to be thereof

SUITABLE AGE PERSON C [ ] by delivering thereat a true copy of each to a person of suitable age and discretion. Said premises is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. [ ] (S) He identified (her) himself as of recipient

AFFIXING TO DOOR, ETC. D [ ] by affixing a true copy of each to the door of said premises, which is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. Deponent was unable, with due diligence to find recipient or a person of suitable age and discretion, thereat, having called there on the dates below:

MAILING USE WITH C or D [ ] Deponent also enclosed a copy of same in a postpaid sealed wrapper properly addressed to the above recipient at and deposited said wrapper in (a post office) official depository under exclusive care and custody of the United States Postal Service within New York State.

Deponent further states that he describes the person actually served as follows

Sex	Skin Color	Hair Color	Age (Approx.)	Height (Approx).	Weight (Approx.)
MALE	WHITE	BROWN	40	5'6	160

GLASSES

MILITARY SERVICE [X] Above person has asked, whether the recipient (s) was (were) in the military service of the State of New York or the United States and received a negative reply. Upon information and belief based upon the conversation and observation as aforesaid deponent avers that the recipient (s) is (are) not in the military service of the State of New York or the United States as that term is defined in the statutes of the State of New York or the Federal Soldiers and Sailors Civil Relief Act.

That at the time of such service deponent knew the person (s) so served as aforesaid to be the same person (s) mentioned and described as the defendant(s) in this action.

USE IN NYC CIVIL CT. [ ] The language required by NYCRR 2900.2(e). (f) & (h) was set forth on the face of said summons (es).

Sworn to before me on the 12/17/02

SANDRA FARRON
Notary Public, State of New York
No. 01FA4784241
Qualified in Nassau County
Commission Expires [illegible]

ANDRE ADAMSON
LICENSE No.
103 8789

756000

NYS DEPT. HEALTH

COUNTY OF

IN THE MATTER OF MILTON SMITH M.D.,

Plaintiff(s)

- against -

Defendant(s)

[illegible] BROADWAY, SUITE 1504
NEW YORK, NY 10007
LIC. # 887-054

Index No.

COURT DATE 01/16/03

AFFIDAVIT OF SERVICE

NOTICEOF HEARING, STATEMENT OF CHARGES, REGULATIONS

STATE OF NEW YORK: COUNTY OF NEW YORK ss:

ANDRE ADAMSON BEING DULY SWORN DEPOSES AND SAYS DEPONENT IS NOT A PARTY TO THIS ACTION AND IS OVER THE AGE OF EIGHTEEN YEARS AND RESIDES IN THE STATE OF NEW YORK.

That on 12/17/02 at 1053AM Hours at 189 MONTAGUE STREET # 801 A BROOKLYN, NEW YORK 11201 deponent served the within NOTICEOF HEARING, STATEMENT OF CHARGES, REGULATIONS on MILTON SMITH M.D. therein named,

INDIVIDUAL A [X] by delivering a true copy of each to said personally; deponent knew the person so served to be the person described as said person therein. [X] (S) He identified (her) himself as such.

CORPORATION B [ ] a (domestic) (foreign) corporation by delivering thereat a true copy of each to personally, deponent knew said corporation so served to be the corporation described in legal papers and knew said individual to be thereof

SUITABLE AGE PERSON C [ ] by delivering thereat a true copy of each to a person of suitable age and discretion. Said premises is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. [ ] (S) He identified (her) himself as of recipient

AFFIXING TO DOOR, ETC. D [ ] by affixing a true copy of each to the door of said premises, which is recipient's (actual place of business) (dwelling house) (usual place of abode) within the state. Deponent was unable, with due diligence to find recipient or a person of suitable age and discretion, thereat, having called there on the dates below:

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Deponent further states that he describes the person actually served as follows

Sex	Skin Color	Hair Color	Age (Approx.)	Height (Approx.)	Weight (Approx.)
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That at the time of such service deponent knew the person (s) so served as aforesaid to be the same person (s) mentioned and described as the defendant(s) in this action.

USE IN NYC CIVIL CT. [ ] The language required by NYCRR 2900.2(e). (f) & (h) was set forth on the face of said summons (es).

Sworn to before me on the 12/17/02

SANDRA FARRON
Notary Public, State of New York
No. 01FA4784241
Qualified in Nassau County
Commission Expires Sept. 30, 2005

ANDRE ADAMSON

LICENSE No.
103 8789

756.000